



Considerations for American Indians in the Health Insurance Exchange

Thursday, September 27, 2012



Foundations of American Indian Health Care Policy

- United States Constitution
- Treaties
- Laws
- Executive Orders
- Court Decisions
- Administrative Agreements



1831

Cherokee Nation v. Georgia

Chief Justice John Marshall established the legal foundation for the *Trust Responsibility* by describing Indian tribes as “*domestic dependant nations*” whose relationship with the United States “*resembles that of a ward to his guardian*”.



1974

Morton v. Mancari

The Supreme Court set the standard of review for laws that establish special treatment for Indians-the “*rational basis*” test. In rejecting a challenge that the application of Indian preference in employment at the Bureau of Indian Affairs was racially discriminatory under the civil rights law, the Court characterized the preference as ***political*** rather than racial.



1976

The Indian Health Care Improvement Act

This comprehensive legislation sought to bring order and direction to health services delivery for Indian people; “The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest necessary to effect that policy.” The act made Indian Health Service hospitals eligible to collect Medicare reimbursements. And, it provided eligibility for the IHS facilities to collect reimbursements from Medicaid and to apply a 100 percent Federal Medical Assistance Percentage (FMAP) to Medicaid services provided to an Indian by an IHS facility.

A decorative vertical border on the left side of the slide, featuring a black vine with various leaves and flowers. The leaves are green, red, and orange, while the flowers are blue and red. The background of the border is a light beige fabric texture.

1998

Executive Order #13084: Consultation and Coordination with Indian Tribal Governments

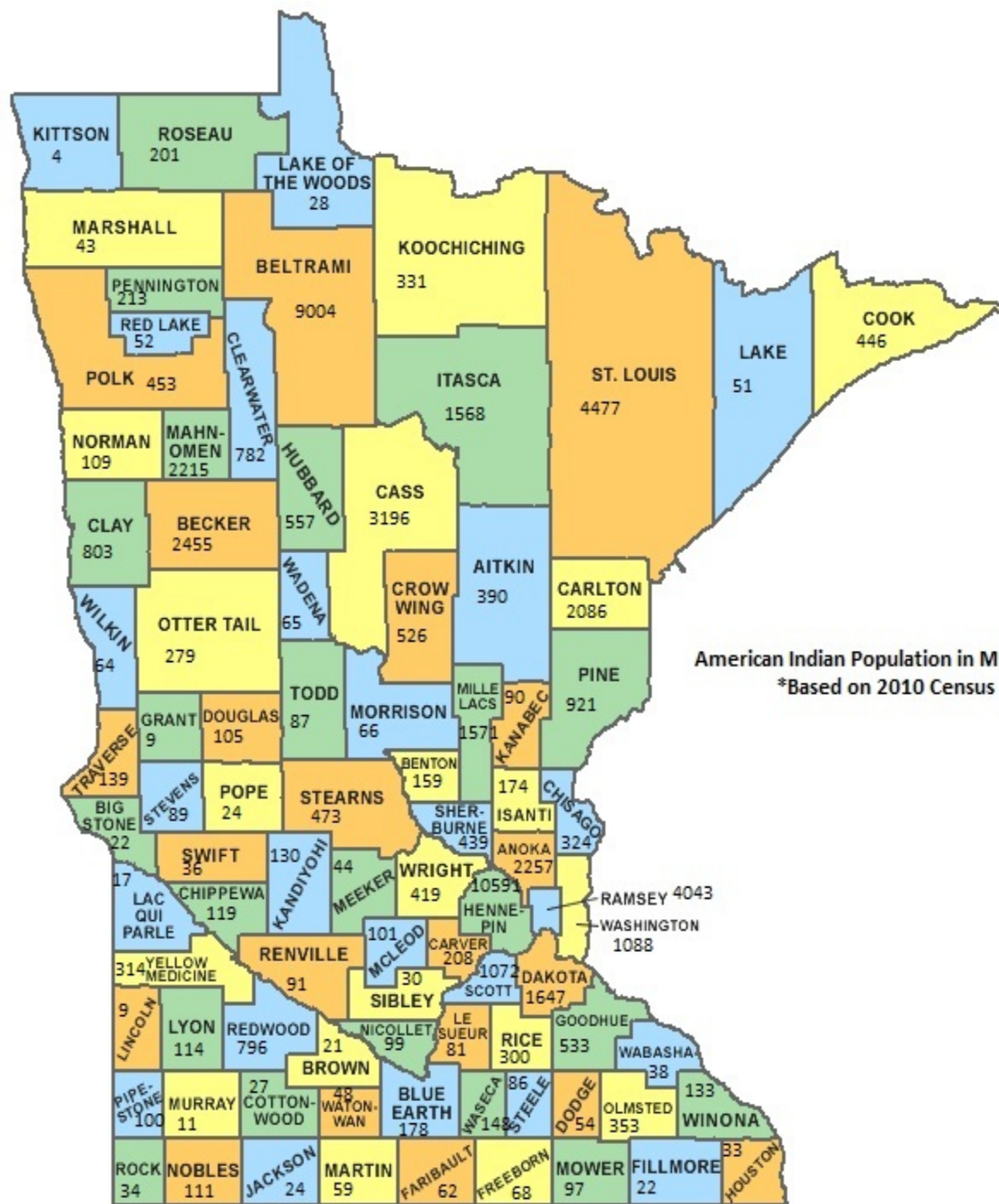
Requires all major departments within the executive branch to consult with Indian tribes when laws and regulations under consideration may have an impact on them.



2010

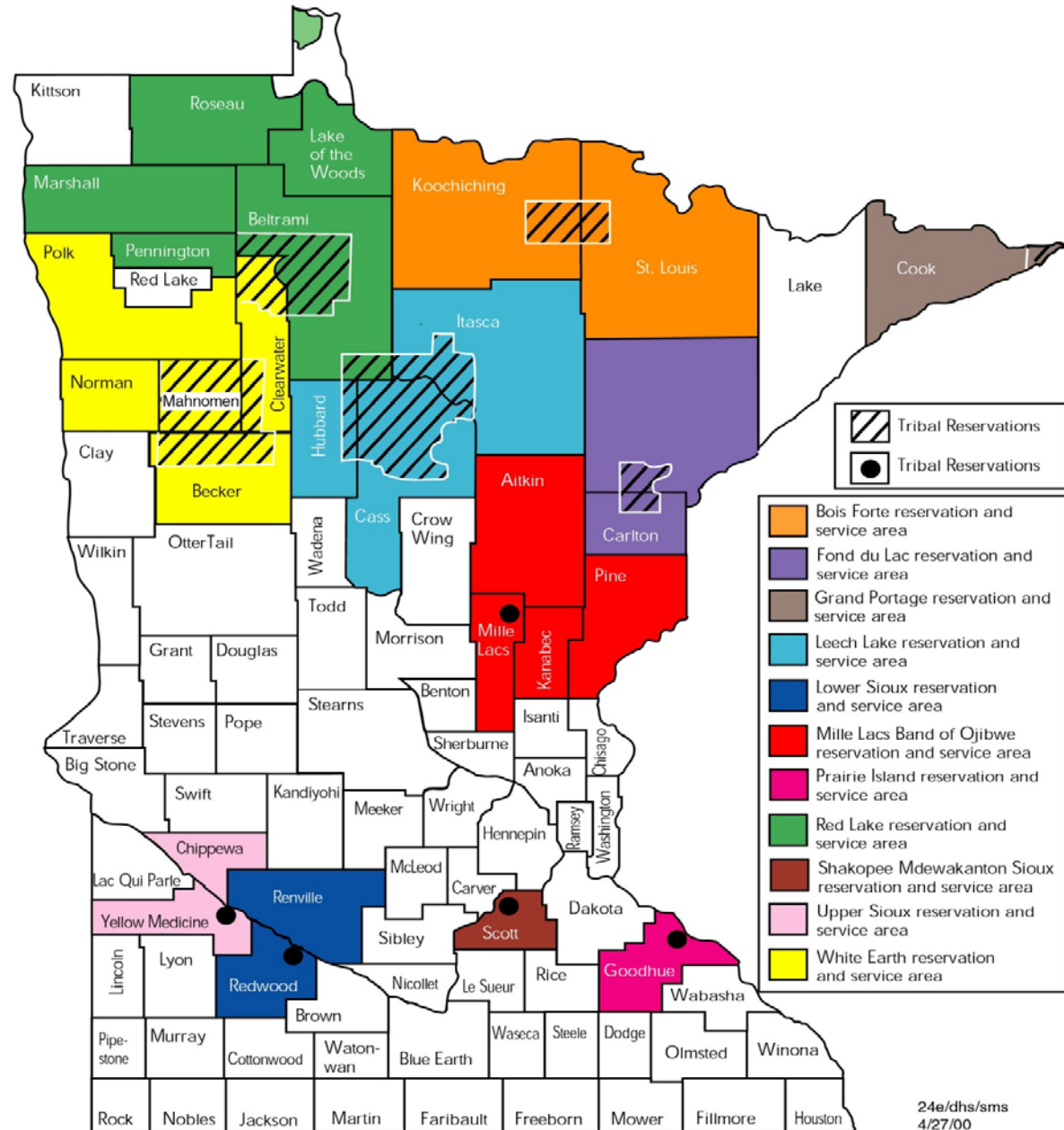
The Patient Protection and Affordable Care Act

- Indian Health Care Improvement Act permanently reauthorized
- Cost sharing protections for American Indians
- Monthly enrollment periods
- Exemptions from tax penalties for not maintaining minimum essential coverage



American Indian Population in MN / County
*Based on 2010 Census

Reservation Map/Contract Health Service Delivery Area

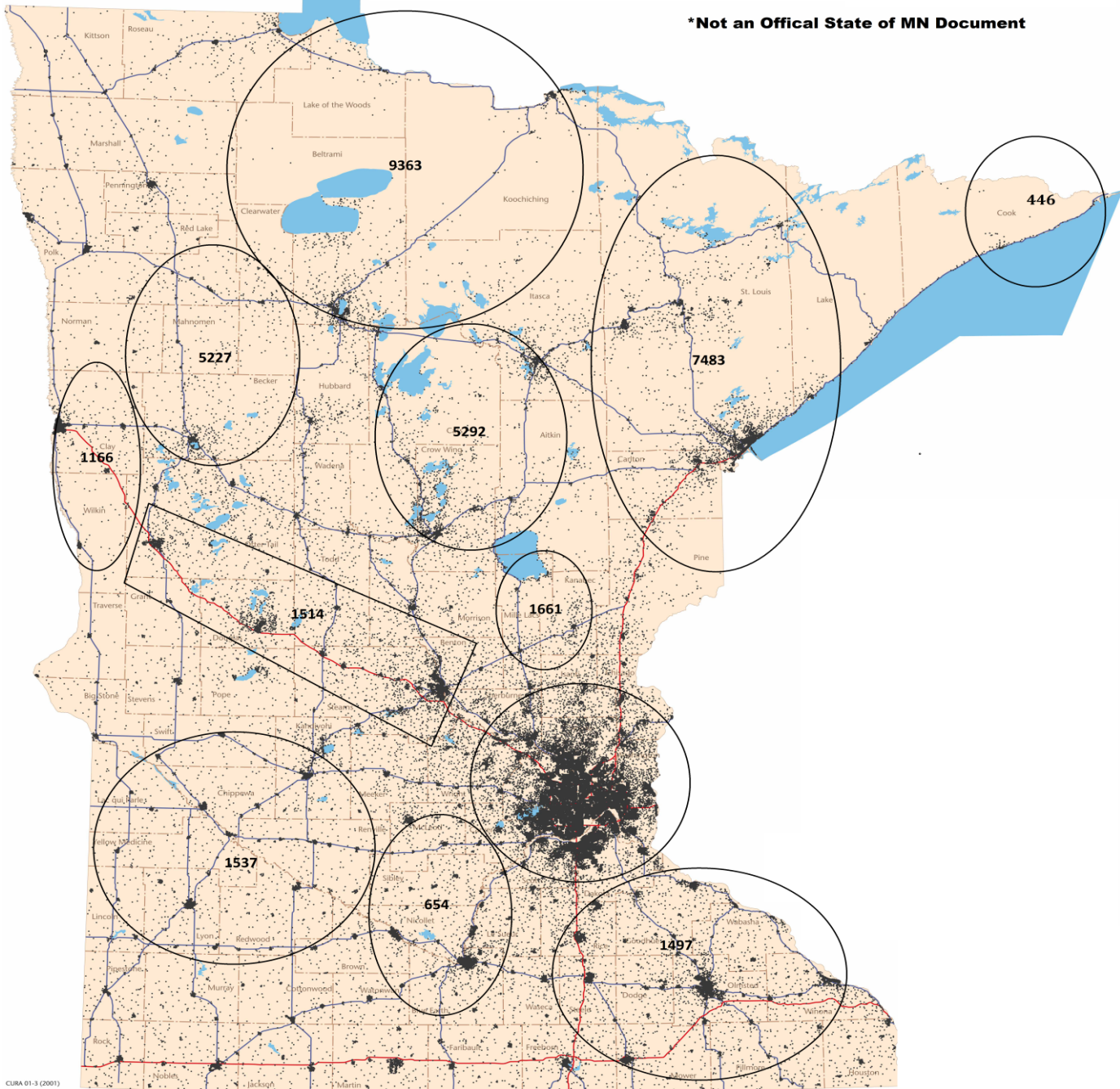


24e/dhs/sms
4/27/00

1. Parts of Beltrami are within both Red Lake and Leech Lake CHSDA
2. Parts of Clearwater are within both Red Lake and White Earth CHSDA
3. Parts of Polk are within both Red Lake and White Earth CHSDA

***Estimated American Indian Populations in MN from 2010 Census Data**

***Not an Official State of MN Document**





Minnesota AIAN Health Insurance Coverage

Minnesota

**AIAN alone and
in combination**

HEALTH INSURANCE COVERAGE

**Civilian non-institutionalized
population**

93,380

With private health insurance

45.6%

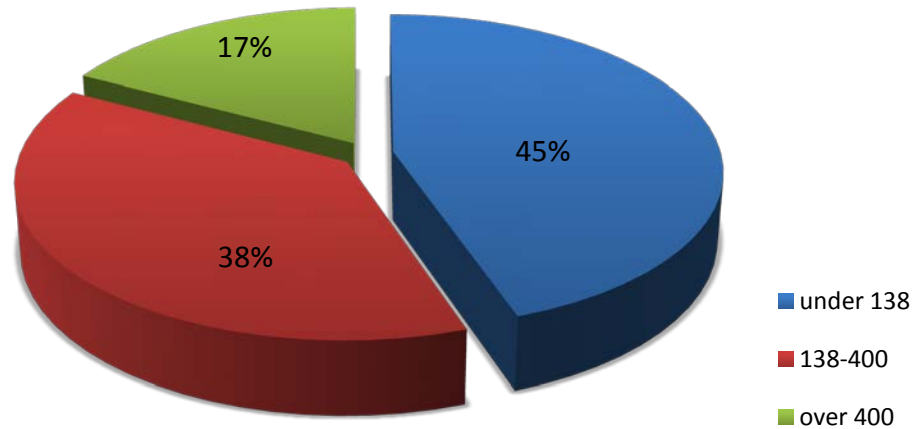
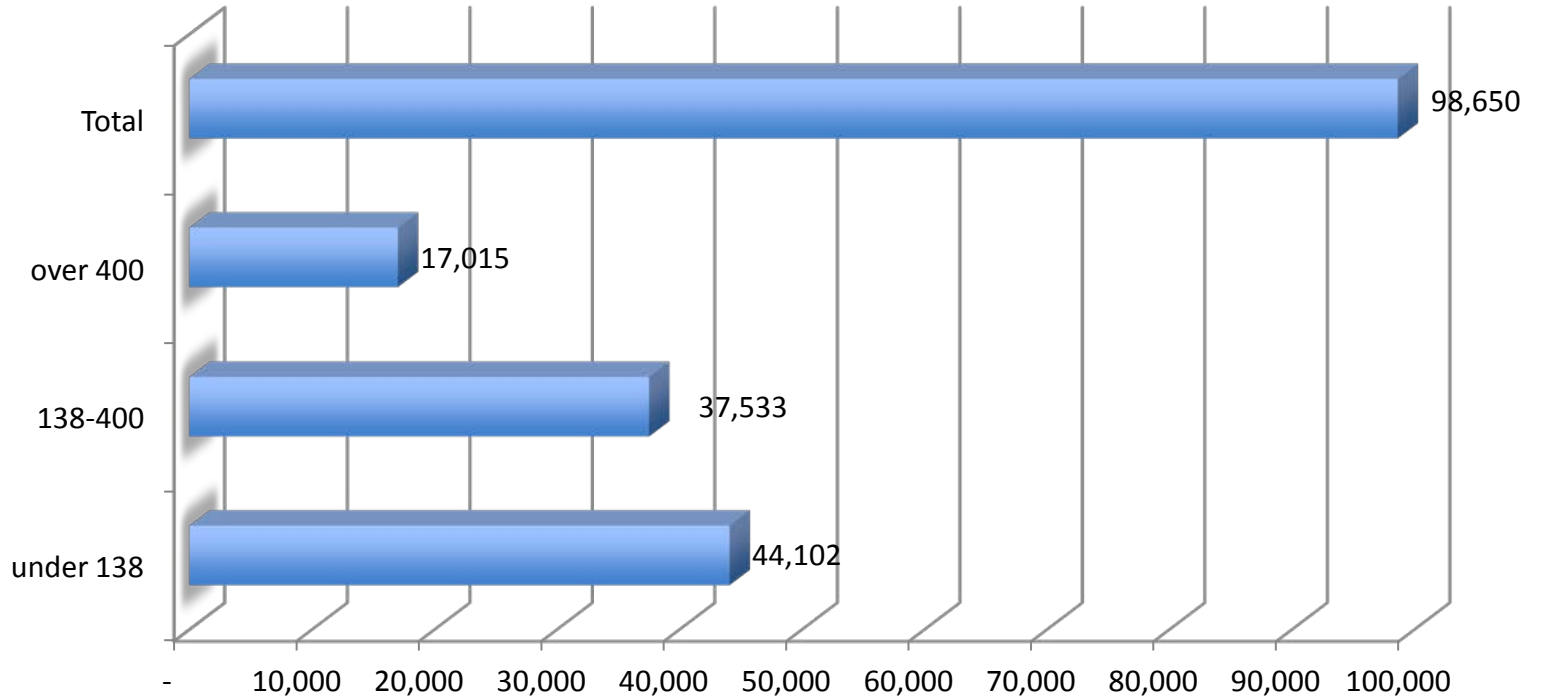
With public coverage

42.1%

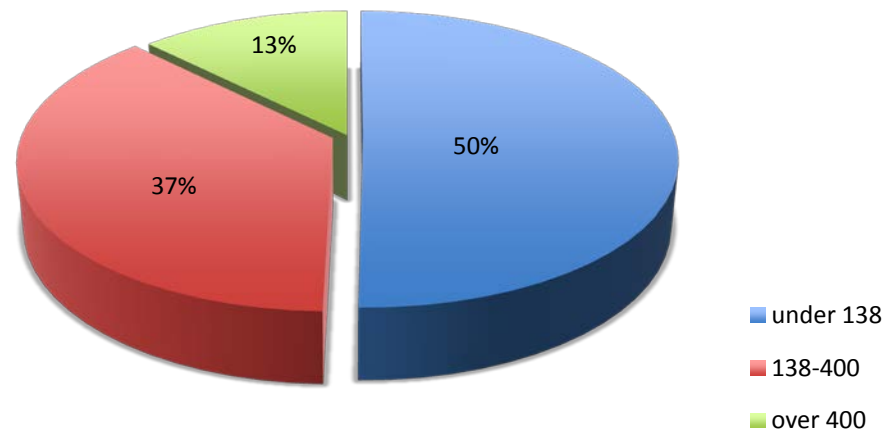
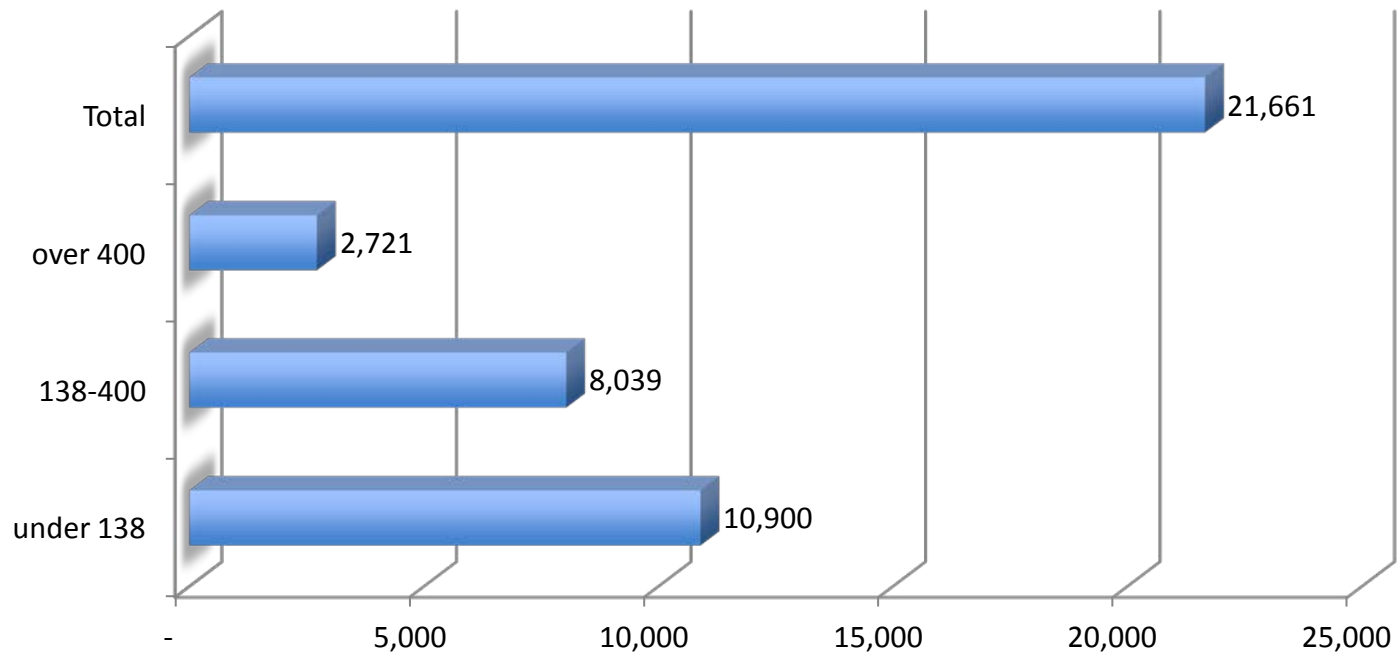
No health insurance coverage

19.3%

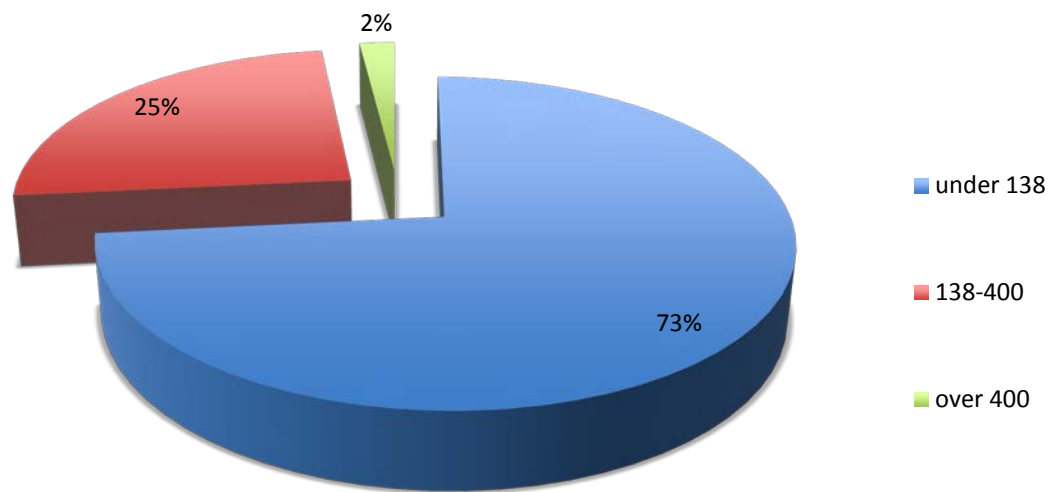
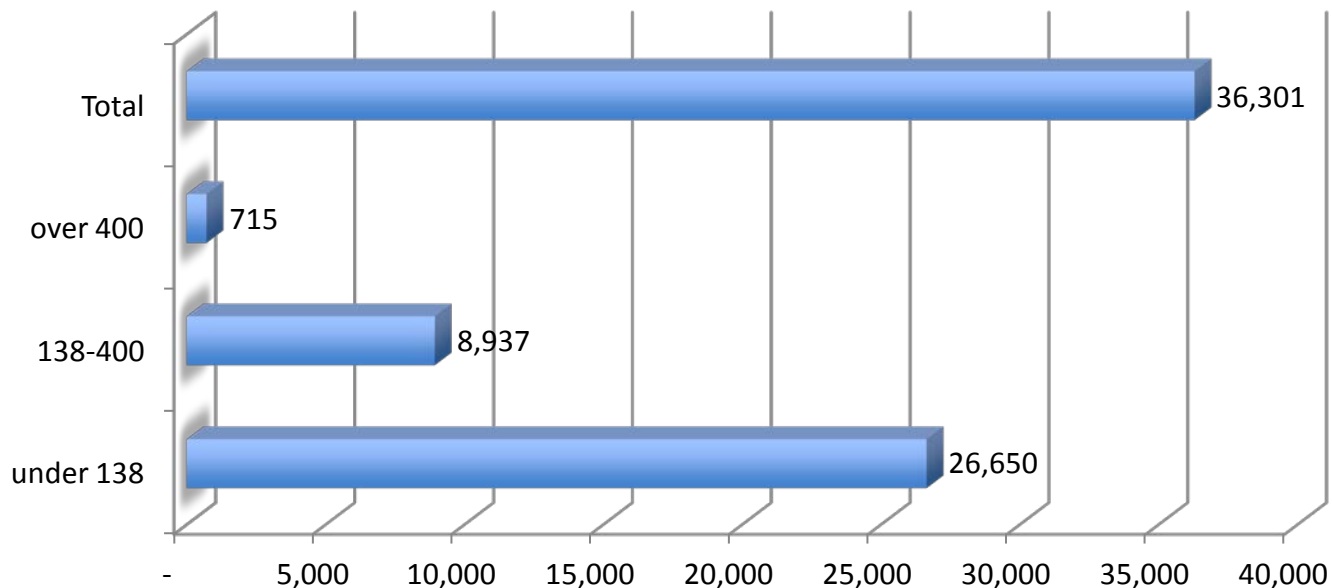
FPL of MN Indians



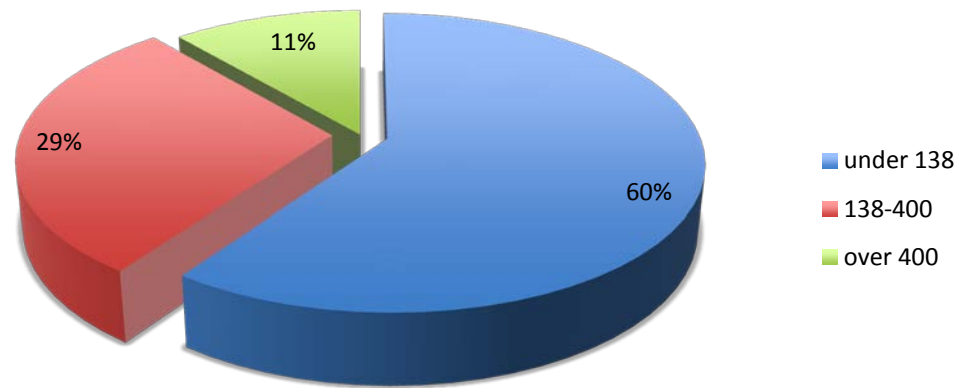
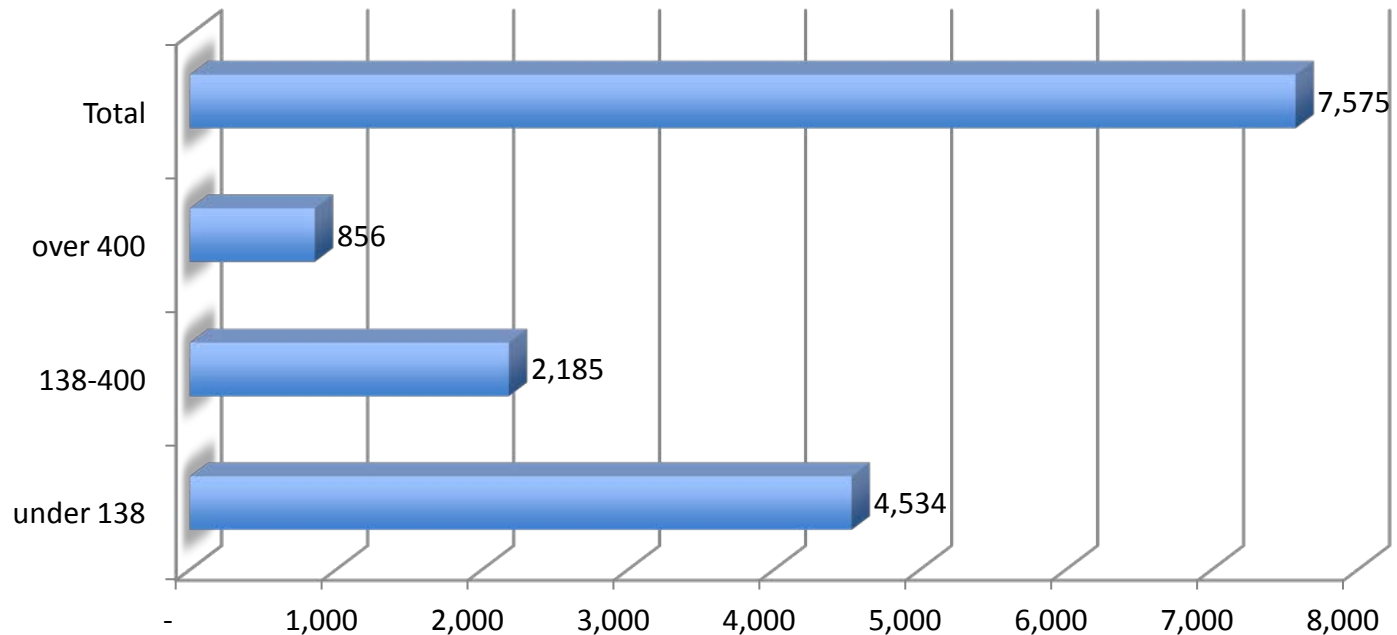
MN Indians Uninsured by FPL



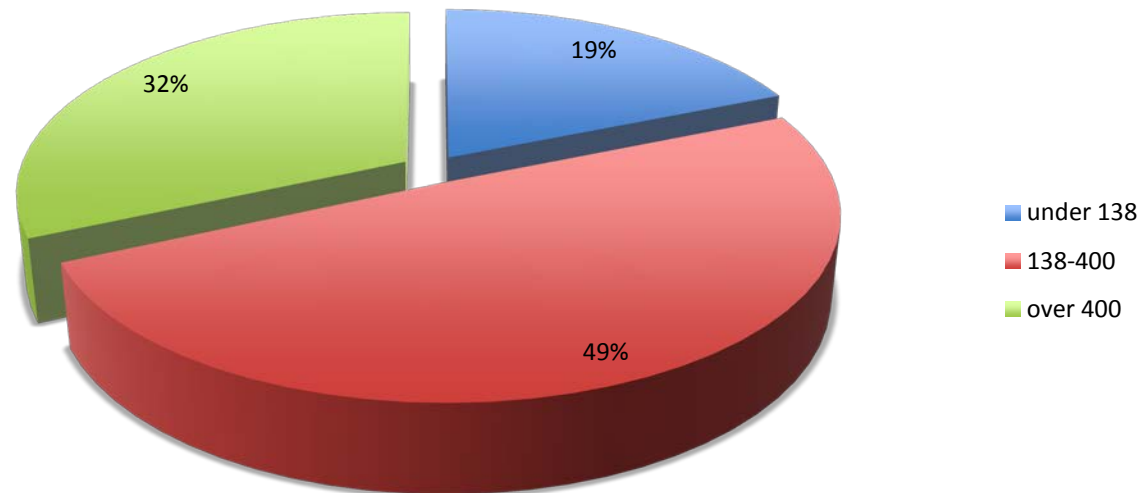
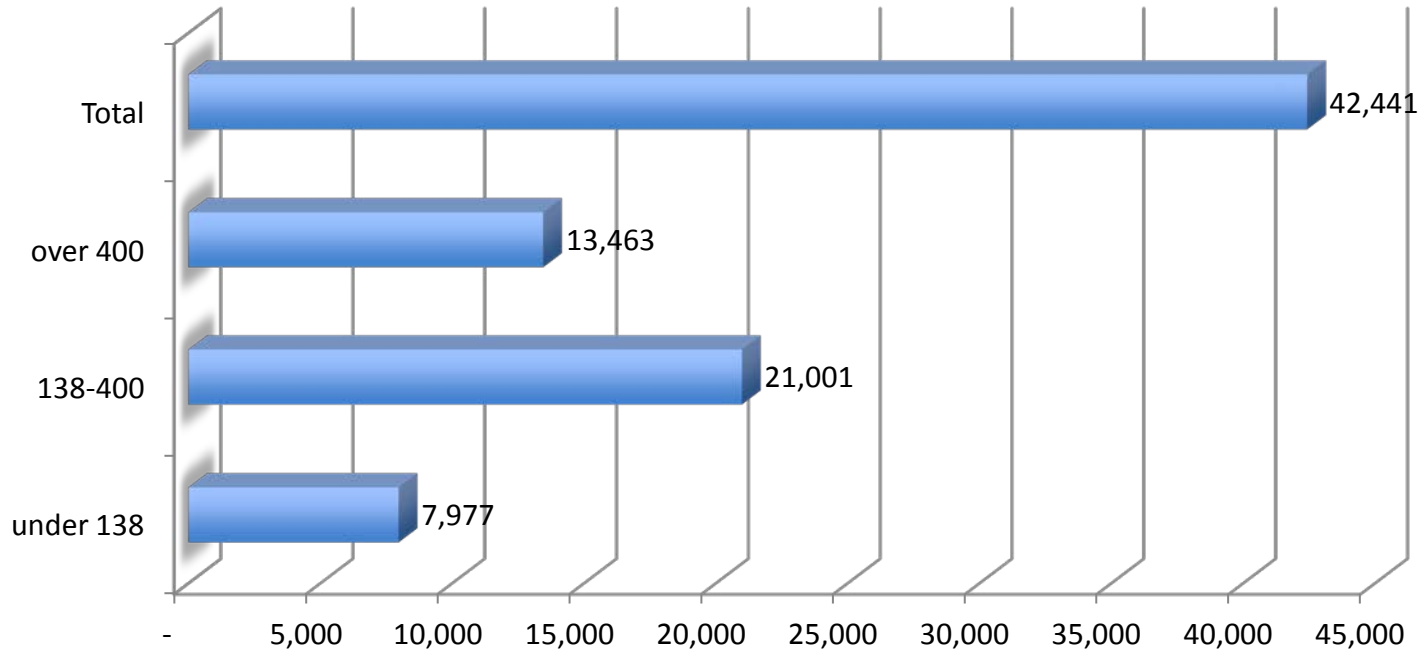
MN Indians on Medicaid by FPL



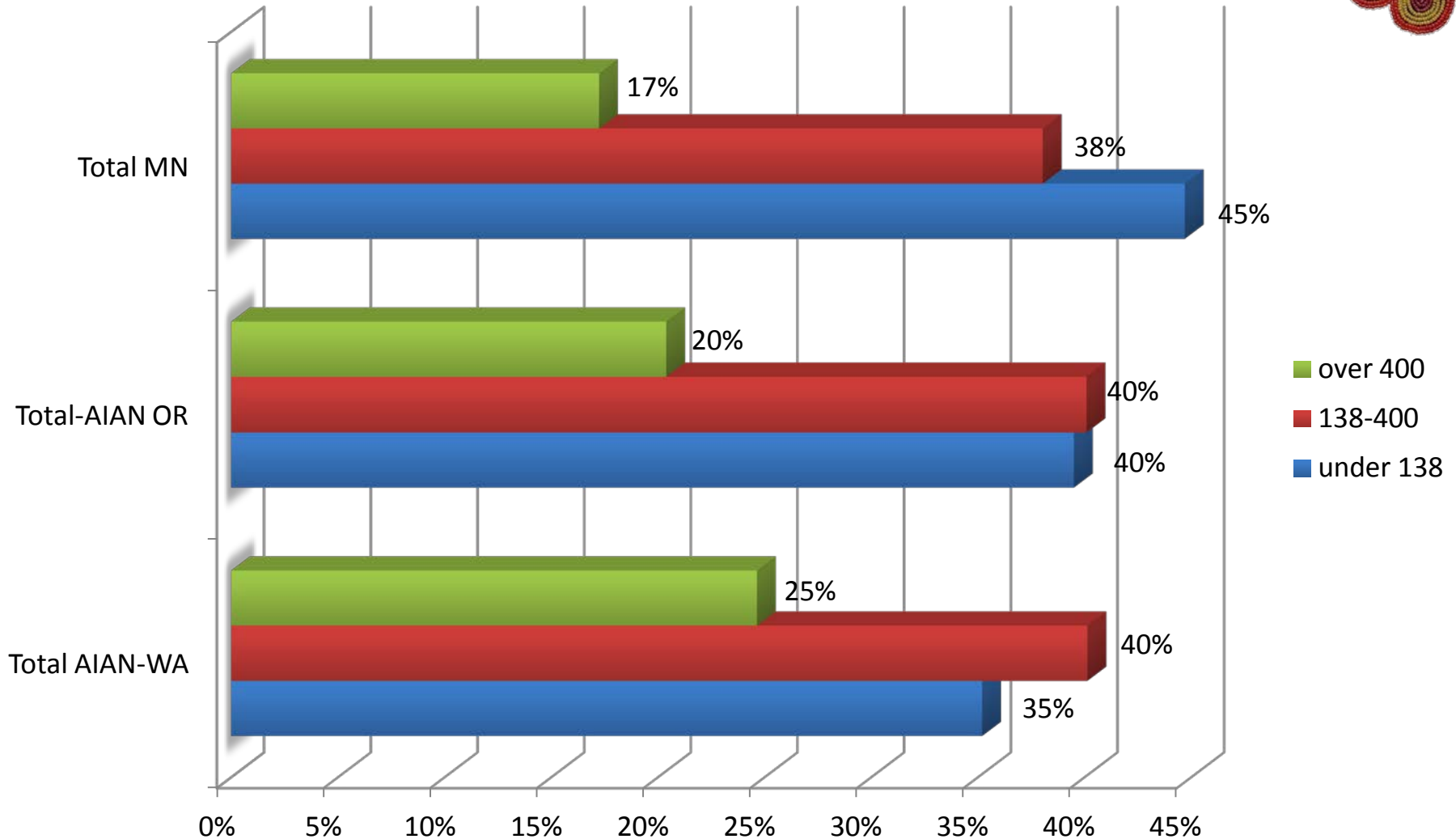
MN Indians on Medicare by FPL



MN Indians with Private Insurance by FPL



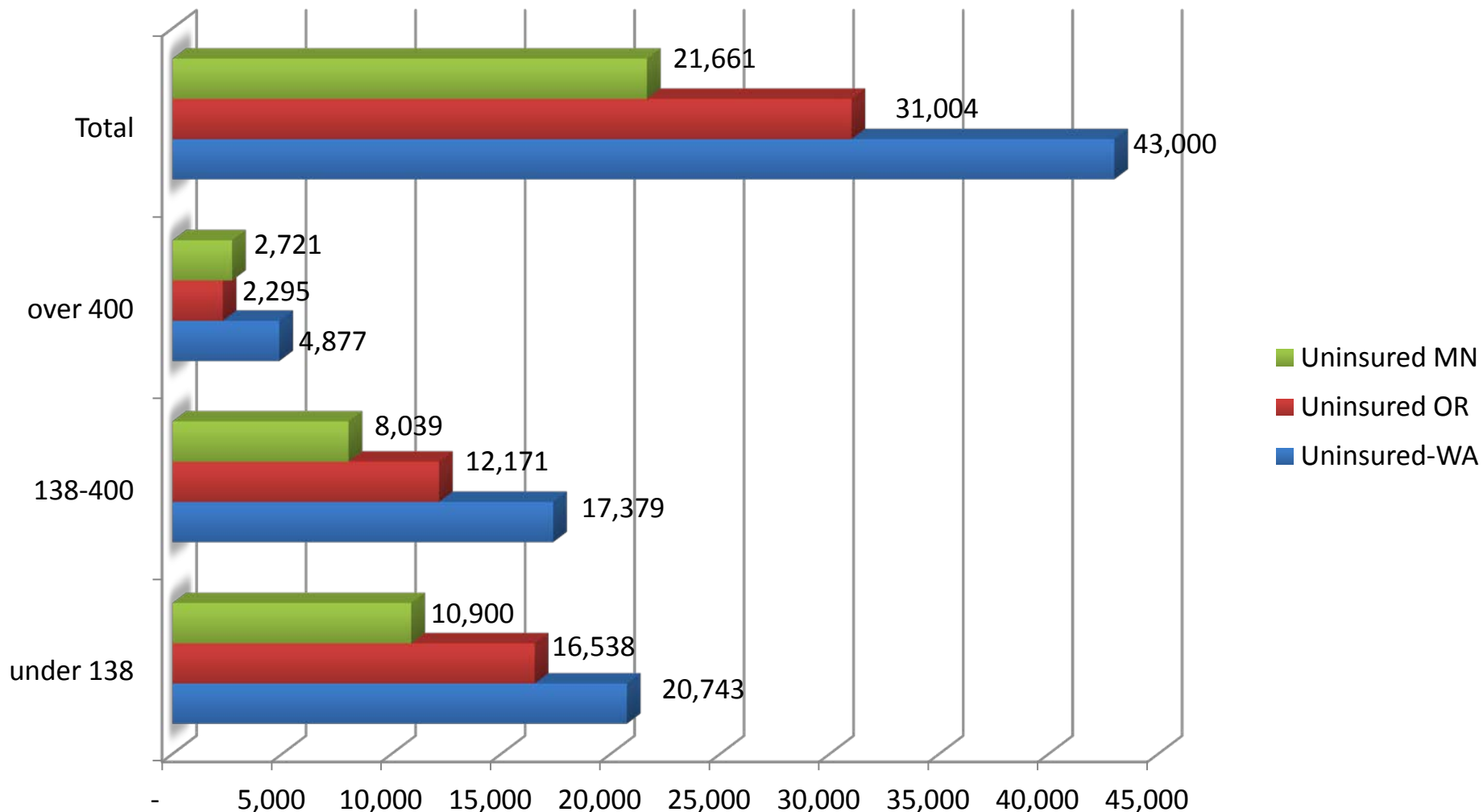
Income Distribution of AIANs by FPL



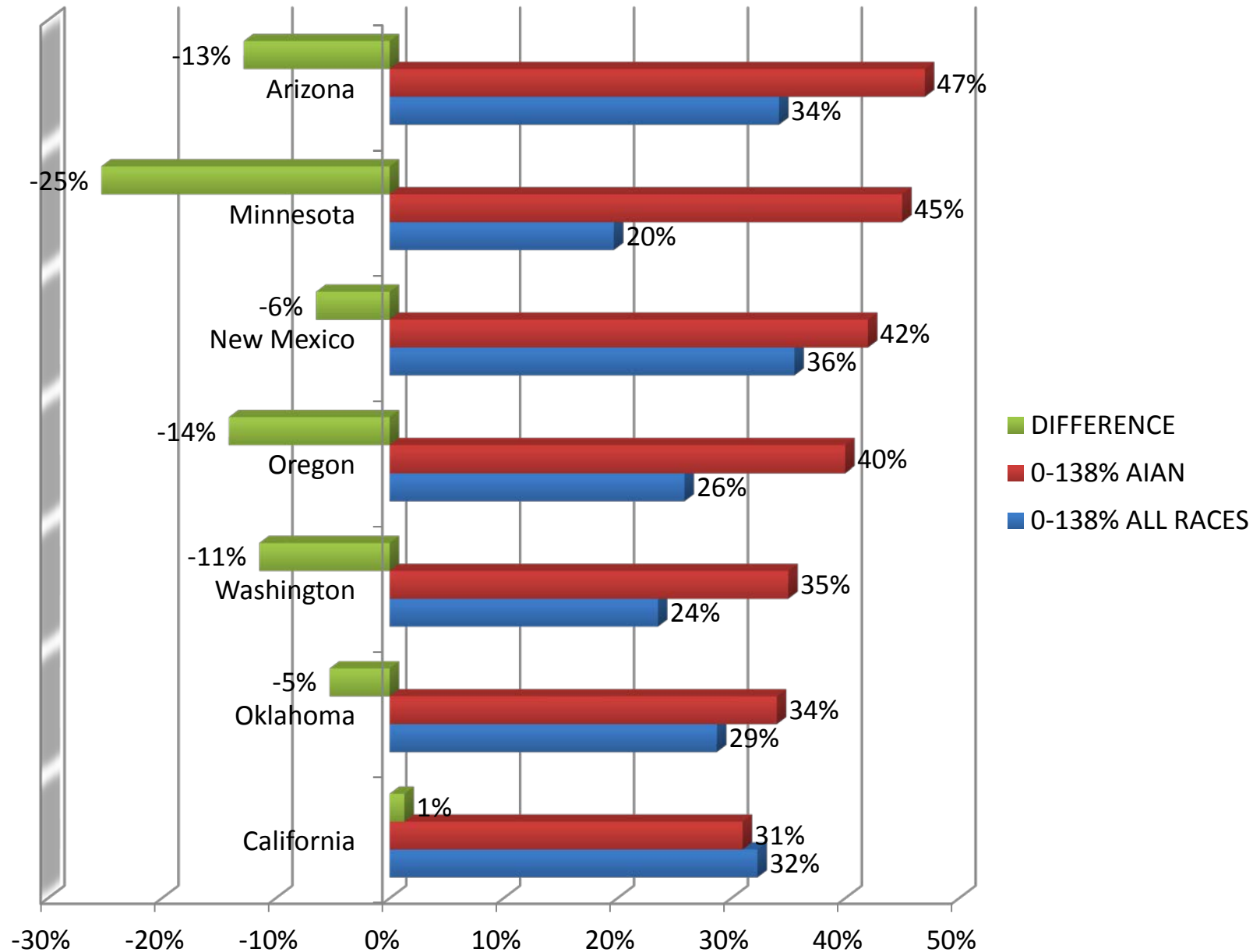
Income distribution of Uninsured AI/AN MN, OR, WA by FPL



Minnesota, Oregon and Washington Uninsured by ACA Income Categories



Comparison of % of AI/ANs under 138% of Poverty to All Races under 138%





AMERICAN INDIAN INSURANCE EXCHANGE ISSUES

- Tribal Consultation Policy: develop, approve, and update.
- Tribal Sponsorship: permit tribal aggregate premium payments to encourage Tribes to sponsor AI's in Exchange plans.
- Network Adequacy: require all QHPs to offer contracts to all I/T/U providers.
- Indian Addendum: require all QHPs to use the Indian Addendum.
- Enforcement of Section 206: assure that the I/T/U is paid in a sufficient and timely way for services delivered to AI's who are enrolled in QHPs if the I/T/U is not a network provider.
- Reimbursements for Waived Cost Sharing: process to assure that the I/T/U receives payment for the co-pays and deductibles that are waived for AI/AN.



AI/AN PATIENT ENROLLMENT ISSUES

- Outreach and Education: provide outreach and education that is culturally appropriate and Indian specific.
- Eligibility: identification of individuals who are eligible for special protections and provisions as AI/AN in the eligibility process and at the provider level to assure that deductibles and co-pays are waived.
- Enrollment: enrollment processes must accommodate not only special provision for AI/AN in Exchanges (monthly enrollment, waiver of cost sharing, exclusion of certain sources of income), but also in Medicaid, Medicaid Expansion, and Minnesota Care.



INFORMATION SYSTEMS ISSUES

- Identification of databases that will be used to expedite eligibility determinations.
- Clarification on how additional documentation will be requested and reviewed for eligibility determinations when individuals are not included in approved data systems.
- Call Centers: decide whether it is most appropriate to have an Indian desk to handle questions and resolve problems regarding AI/AN and I/T/Us, or whether everyone who works at a call center should receive training about Tribes in the State, the Indian health care delivery system and special provisions in the law, regulations and systems for AI/AN.
- Website: ensure that the design of the website includes information specific to AI/AN and the I/T/U and is easy to access by consumers, as well as those assisting with enrollment.



INFORMATION SYSTEMS ISSUES

continued

- Waiver of Penalties for AI/AN without Insurance: develop the system to assure that individuals are not penalized and identify who is covered by this provision in the law.
- Referrals through Contract Health Services (CHS): rules and processes to assure that AI/AN who are enrolled in a QHP and referred through an I/T/U CHS program are not charged a co-pay or deductible for services they receive outside the I/T/U.
- Reimbursements for Waived Cost Sharing: develop a process to assure that the I/T/U receives payment for the co-pays and deductibles that are waived for AI/AN, and that the Plans receive full credit for cost sharing losses.